STATE OF NEW JERSEY
DEPARTMENT OF LAW & PUBLIC SAFETY
DIVISION OF CONSUMER AFFAIRS
BOARD OF NURSING

IN THE MATTER OF THE SUSPENSION OR REVOCATION OF THE LICENSE OF OTUNIYA AUGUSTINA NDEGO, R.N. LICENSE NO. NR88488 TO PRACTICE NURSING IN THE STATE OF NEW JERSEY	Administrative Action FINAL ORDER GRANTING JUDGMENT BY DEFAULT

This matter was opened to the New Jersey State Board of Nursing ("the Board") upon the filing by Paula T. Dow, then-Attorney General of New Jersey, Deputy Attorney General Doreen A. Hafner appearing, of an Administrative Complaint, Notice of hearing and Notice to File an Answer on October 29, 2010. The Complaint alleged that respondent, on or about September 4, 2006, while employed at Our Lady of Lourdes Medical Center, failed to assess patient J.G., and thereby engaged in gross negligence, gross malpractice or gross incompetence in violation of N.J.S.A. 45:1-219c); repeated acts of negligence, malpractice or incompetence in violation of N.J.S.A. 45:1-21(d); and professional misconduct in violation of N.J.S.A. 45:1-21(e).

Pursuant to a Notice of Motion for Default and Default Judgment submitted on May 25, 2011, D.A.G. Hafner appeared before the Board on or about July 8, 2011 seeking suspension or revocation of respondent's nursing license. As set forth in the

State's supporting certifications, copies of the Notice of Hearing and Notice to File Answer and the Administrative Complaint had been served upon respondent at her address of record by certified mail, return receipt requested and regular mail, both mailings having been sent on November 1, 2010. The certified mailing was returned to the Attorney General's office as "unclaimed," and the regular mailing of the documents was not returned. Moreover, on November 8, 2010, the Administrative complaint and accompanying documents were sent via UPS 2nd Day Air to respondent's address of record, and were delivered on November 9, 2010. Although the Notice of Hearing and Notice to File an Answer required respondent to file an Answer to the Complaint within thirty-five (35) days from service of the Complaint, no response had been received as of the return date of the Motion for Default of July 8, 2011.[1]

The Complaint alleged that patient J.G., a 73-year-old male, was admitted to Our Lady Of Lourdes with a diagnosis of Altered Mental Status and Generalized Weakness. On September 4, 2006, at approximately 12:18 p.m., a telemetry technician noticed that patient J.G.'s heart rate had changed to an Accelerated Idioventricular Rhythm. The unit secretary was notified, and she called on the overhead intercom for the

[1] Although the Board heard this matter on July 8, 2011, due to administrative oversight, no order was entered at that time. As Ms. Ndego's New Jersey license has been in "expired" status since May 31, 2011, issuance of this order at this time should not prejudice respondent.

telemetry to be checked for patient J.G. Within seconds, the heart rhythm changed again twice. The unit secretary shouted out that patient J.G.'s telemetry should be checked, and respondent heard the call and went to J.G.'s room to check on patient J.G. When she reached the room, she saw that an Echocardiogram (EEG) Technician was present, performing an EEG. Respondent did not physically examine patient J.G., check the telemetry monitor, or look at the rhythm strips for the patient. Instead, she told the unit secretary that the EEG administration was interfering with the telemetry monitoring, and patient J.G. was not in distress.

At approximately 12:45 p.m. the EEG technician asked the unit secretary to call for an EKG, because she believed the patient was not breathing. Patient J.G. was estimated to have died at 12:23 p.m.

Sworn statements from Tanya Tingle, the unit secretary; Denise Morris, the telemetry technician and Ingrid Ricketts, the EEG technician, were submitted as Exhibit F in support of the Complaint's depiction of the surrounding circumstances.

In a statement signed on May 3, 2007, directed to the Board of Nursing, Nurse Ndego admitted that she had assumed that the patient was alert and working with the technician who was administering the EEG, and she did not perform any assessment of the patient.

An Expert Witness Report from Fay Spragley, R.N. dated September 1, 2010, found that Nurse Ndego deviated from the standard of care by failing to assess the patient, i.e., failing to collect the subjective and objective data required to make a diagnosis and subsequently implement an intervention. The expert's report further found that respondent failed to follow the hospital's policy and procedure by failing to look at the rhythm strips to verify the information provided by the telemetry assistant's call, or to assess the patient to verify that information. By failing to perform an adequate assessment, Ms. Spragley found that respondent placed the patient's safety and life in danger. (State's Exhibit H) Nurse Spragley explained:

> When the telemetry technician called that the patient needed to be checked it is obvious that it is related to a cardiac dysrhythmia or nonfunctioning equipment. By responding to the request to check the patient, Ms. Ndego had an obligation and a duty to the patient to perform an assessment. She failed to observe the patient's clinical status, and failed to comply with the facility's policy and procedural guidelines. Seeing an EEG technician in the room performing a diagnostic test does not substitute for an assessment of the patient, or the equipment. Assessment of a patient cannot be omitted, nor delegated to an EEG technician, without putting the patient at risk of harm.

The Notice of Motion for Default and Default Judgment, and its accompanying letter brief and Certification of Counsel were sent to respondent by certified and regular mail on May 25,

2011. On that same date, those documents were sent to respondent by UPS two day mail. The certified mailing was signed for, the regular mailing was not returned, and the documents sent by second day air were delivered on May 26, 2011. Accordingly, the Board finds that service was effected of both the Administrative Complaint, Notice of hearing and Notice to File an Answer, filed on October 29, 2010, and of the Notice of Motion for Default and Default Judgment.

The Board then considered the evidence presented in this matter. Having considered the Attorney General's submissions, including the supporting certifications and respondent's admissions, as well as respondent's failure to contest the allegations, the Board finds that the State has provided ample proof of the allegations in the Administrative Complaint and grants judgment by default. The Board finds that respondent's failure to assess patient J.G. or to verify the rhythm data under the circumstances constituted gross or repeated negligence, malpractice or incompetence within the intendment of N.J.S.A. 45:1-21 (c) and (d), and professional misconduct in violation of N.J.S.A. 45:1-21(e), as alleged in the Complaint. As the State's expert averred in her report, when respondent arrived upon the scene, she proceeded to assess, not the patient, but "the situation in the room." Respondent assumed that, because an EEG technician was present, the telemetry data

indicating heart rhythm irregularities did not reflect the true condition of the patient. To rely upon this assumption, without verifying its accuracy, was a gross violation of the standard of care, and may have meant the difference between life and death for this patient, who died within a short time thereafter.

The Attorney General argued that respondent's gross deviation from the standard of care warranted revocation or suspension of respondent's nursing license. The Board finds that respondent's failure to assess patient J.G. under the circumstances was tantamount to an abdication of respondent's obligations as a nurse to protect patients, and that a two year suspension of license should be imposed, a significant sanction which reflects the gravity of the conduct.

The Attorney General also sought investigative costs, attorneys fees and an expert witness's fee in this matter. Respondent is in default and therefore has not filed any documents, including any objections to costs. D.A.G. Hafner's certification, an attorney timesheet report, a Certification of Costs signed by Cyndy M. Gohl, Supervising Investigator, and an invoice for the services of expert Fay Spragley were included in the documents served upon respondent with the Notice of Motion for Default and Default Judgment.

We have reviewed the costs sought in this matter and find the application sufficienty detailed and the amounts claimed

reasonable given the nature of the investigation and the activities performed. Attorneys fees of $1,837.50 were calculated based upon a billing rate of $175.00 per hour for D.A.G. Hafner's time; that is the uniform rate for a Deputy Attorney General of more than ten years experience, pursuant to the policy of the Department of Law And Public Safety, Division of Law, effective May 1, 2005. We are aware that the amount is significantly below the community standard for attorneys fees. We are satisfied that the 10.5 hours billed for the preparation of the Notice of Motion, the brief and D.A.G. Hafner's certification are eminently reasonable, even modest. We find the $3,600.00 billed by expert Fay Spragley for her report, which she indicated required 18 hours to prepare, at a rate of $200.00 per hour, is also reasonable.

In seeking investigative costs, the State has submitted the certification of Supervising Investigator Cyndy Gohl, explaining the manner in which investigative costs were calculated, along with "activity reports" identifying the precise activities performed and the amount of time spent in each activity by the investigators assigned to this matter. Investigative costs totaled $5,708.21. We find the detailed contemporaneous time record supporting these costs to be sufficient. We note that investigative time records are kept in the ordinary course of business by the Enforcement Bureau, the investigative arm of the

Division of Consumer Affairs. We find the overall amount of investigative time expended, 34 hours and 25 minutes, is not excessive for an investigation of this nature, where a patient death was implicated. We have also considered and find that the hourly rate of $116.80 charged is reasonable, and take notice that investigative costs, approved many times in the past by the various professional and occupational boards and committees of the Division of Consumer Affairs, are based on salaries, overhead and costs of state employees. Considering the important State interest to be vindicated, protection of the public health, safety and welfare, we find the investigative costs reasonable.

Accordingly,

IT IS ON THIS 16th DAY OF July, 2012,

ORDERED THAT:

1. The nursing license of respondent Otuniya Augustina Ndego, R.N. shall be suspended for a two year period, effective ten days after the filing of this Order.

2. Pursuant to N.J.S.A. 45:1-25, attorneys fees in the amount of $1,837.50, investigative costs in the amount of $5,708.21, and expert costs in the amount of $3,600.00 are imposed, for a total amount due of $11,145.71. Payment shall be in the form of a certified check or money order, made payable to the State of New Jersey, and sent to the attention of George

Hebert, Executive Director, Board of Nursing, P.O. Box 45010, 124 Halsey Street, 6th Floor, Newark, NJ 07101.

3. Payment shall be due within twenty-one (21) days of the filing of this Order. In the event that respondent wishes to enter into a payment plan, she shall forward a petition to that effect to the attention of George Hebert within twenty-one (21) days, proposing payment terms. In the event that no payment, or no proposal of any payment plan, has been received within twenty-one (21) days after the filing of this order, a certificate of debt may be filed.

4. Upon any request by respondent for reinstatement of license after completion of the period suspension imposed by this Order, the Board reserves the right to require respondent to appear before the Board, and/or to require that respondent demonstrate her competency and/or knowledge by requiring completion of a course or courses, in addition to required continuing education, remedying any deficiencies in assessment or critical thinking that the Board may find. Additionally, the Board may impose any limitations or restrictions on any reinstated license it deems appropriate under the circumstances.

NEW JERSEY STATE BOARD OF NURSING

By: _____
Patricia Ann Murphy, PhD, APN, C
Board President